

(8) *Termination of composition standard.* The 50 percent composition of Medicare beneficiaries terminates for all managed care plans on December 31, 1998.

(e) *Standard: Open enrollment.* (1) Except as specified in paragraph (e)(2) of this section, an HMO or CMP must enroll Medicare beneficiaries on a first-come, first-served basis to the limit of its capacity and provide annual open enrollment periods of at least 30 days duration for Medicare beneficiaries.

(2) HCFA may waive the requirement of paragraph (e)(1) of this section if compliance would prevent compliance with the limitation on enrollment of Medicare beneficiaries and Medicaid recipients (paragraph (d) of this section) or result in an enrollment substantially nonrepresentative of the population of the HMO's or CMP's geographic area. The enrollment would be "substantially nonrepresentative" if the proportion of a subgroup to the total enrollment exceeded, by 10 percent or more, its proportion of the population in the HMO's or CMP's geographic area, as shown by census data or other data acceptable to HCFA. For purposes of this paragraph, a subgroup means a class of Medicare enrollees as defined in §417.582.

[50 FR 1346, Jan. 10, 1985, as amended at 56 FR 46570, Sept. 13, 1991; 58 FR 38082, July 15, 1993; 60 FR 45676, Sept. 1, 1995; 63 FR 35066, June 26, 1998]

§417.414 Qualifying condition: Range of services.

(a) *Condition.* The HMO or CMP must demonstrate that it is capable of delivering to Medicare enrollees the range of services required in accordance with this section.

(b) *Standard: Range of services furnished by eligible HMOs or CMPs.* (1) *Basic requirement.* Except as specified in paragraph (b)(3) of this section, an HMO or CMP must furnish to its Medicare enrollees (directly or through arrangements with others) all the Medicare services to which those enrollees are entitled to the extent that they are available to Medicare beneficiaries who reside in the HMO's or CMP's geographic area but are not enrolled in the HMO or CMP.

(2) *Criteria for availability.* The services are considered available if—

(i) The sources are located within the HMO's or CMP's geographic area; or

(ii) It is common practice to refer patients to sources outside that geographic area.

(3) *Exception for hospice care.* An HMO or CMP is not required to furnish hospice care as described in part 418 of this chapter. However, HMOs or CMPs must inform their Medicare enrollees about the availability of hospice care if—

(i) A hospice participating in Medicare is located within the HMO's or CMP's geographic area; or

(ii) It is common practice to refer patients to hospices outside the geographic area.

(c) *Standard: Financial responsibility for services furnished outside the HMO or CMP.* (1) An HMO or CMP must assume financial responsibility and provide reasonable reimbursement for emergency services and urgently needed services (as defined in §417.401) that are obtained by its Medicare enrollees from providers and suppliers outside the HMO or CMP even in the absence of the HMO's or CMP's prior approval.

(2) An HMO or CMP must assume financial responsibility for services that the Medicare enrollee attempted to obtain from the HMO or CMP, but that the HMO or CMP failed to furnish or unreasonably denied, and that are found, upon appeal by the enrollee under subpart Q of this part, to be services that the enrollee was entitled to have furnished to him or her by the HMO or CMP.

[50 FR 1346, Jan. 10, 1985, as amended at 58 FR 38078, July 15, 1993; 60 FR 45677, Sept. 1, 1995]

§417.416 Qualifying condition: Furnishing of services.

(a) *Condition.* The HMO or CMP must furnish the required services to its Medicare enrollees through providers and suppliers that meet applicable Medicare statutory definitions and implementing regulations. The HMO or CMP must also ensure that the required services, additional services, and any other supplemental services for which the Medicare enrollee has contracted are available and accessible